Nipper Knolls Inc.

196 Auney Way   Granville   NY 12832
518-642-2252

Physician's Prescription

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Participant's Medical History

Participant: ____ D.O.B: ________________ Height: _________ Weight: __________
Address: ____
Diagnosis: ____ Date of Onset: ________________
Medications: ____
Seizure Type: _______________________________________ Controlled: Y N Date of last seizure: ______________________________________
Shunt Present: Y N Date of last revision: ______________ Special Precautions/Needs ____
____
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices: ____
For those with Down syndrome: AtlantoDens Interval X-rays: Date: _____________________ Results: + -
Neurologic Symptoms of Atlanto Axial Instability: ____

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Please indicate current or past special needs in the following systems/area, including surgeries:

Concern/Need:	Yes	**No**	**Comments:**	**Concern/Need:**	**Yes**	**No**	**Comments:**
Auditory				Neurologic			
Visual				Muscular			
Tactile Sensation				Balance			
Speech				Orthopedic			
Cardiac				Allergies			
Circulatory				Learning Disability			
Integumentary/Skin				Cognitive			
Immunity				Emotional/Psych.			
Pulmonary				Pain			
Other:							

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies.
I understand that the therapist/ instructor will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the Nipper Knolls Inc. for ongoing evaluation to determine eligibility for participation.

Physician Prescription:

◯ Therapeutic/Adaptive Horsemanship lessons for 12 months

Name/Title: ____ MD DO NP PA Other: _______________________________________
Signature: ____ Date: _____________________________
Address: ____
Phone: (_____) ______________________ License/UPIN Number: ____

Revised 4/29/2020

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